Maine Bureau of Insurance
Form Filing Requirements Checklist
Group Hospital Confinement Indemnity (H14G)
(Revised 10/1/2018)

Confirm compliance and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING in the last column. N/A: Check this box if a contract does not have to meet this requirement and EXPLAIN WHY in the last column.

State Benefit/Provision and/or ACA Requirement	State Law/ Rule and/or Federal Law	State Description of Requirement and/or ACA Description of Requirement	N/A →	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING MUST EXPLAIN WHY REQUIREMENT IS NOT APPLICABLE
GENERAL REQUIREMENTS				
Electronic (SERFF) Submission Requirements	24-A M.R.S.A. §2412 (2) Bulletin 360	All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com.	☐	
FILING FEES	24-A M.R.S.A. §601(17)	$20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report.	☐	
Grounds for disapproval	24-A M.R.S.A. §2413	Seven categories of the grounds for disapproving a filing.	☐	
Readability	24-A M.R.S.A. §2441	Minimum of 50. Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF.	☐	
Variability of Language	24-A M.R.S.A. §2412	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of	☐	

	§2413	too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations.		

EXCEPTED BENEFIT REQUIREMENTS				
Coordination of Benefits	42 CFR § 146.145(b)(4)(ii)(B)	There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.	☐	
New Sales Application Materials Notice	42 CFR § 148.220(b)(4)(iv)	A notice is displayed prominently in the application materials in at least 14 point type that has the following language: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES." This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate.	☐	
Payment of Benefits	42 CFR § 146.145(b)(4) 42 CFR § 146.145(b)(4)(ii)(C)	The insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.	☐	

Renewal Notice	42 CFR § 148.220(b)(4)(iv) Bulletin 396	A notice is displayed prominently in the application materials in at least 14 point type that has the following language: **"THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."** This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate. If no application for renewal is required because the policy or certificate renews automatically upon continued payment of premiums, then no later than October 1, 2016, the carrier shall send notice to each insured who was not given notice at the point of sale. The Bureau suggests that carriers use language substantially similar to the following notice: **"THIS INSURANCE POLICY DOES NOT MEET THE AFFORDABLE CARE ACT'S REQUIREMENT THAT YOU MAINTAIN MINIMUM ESSENTIAL COVERAGE, ALSO KNOWN AS MAJOR MEDICAL INSURANCE. FAIL URE TO MAINTAIN MINIMUM ESSENTIAL HEAL TH COVERAGE MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE COVERAGE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS."**	☐	

Required Disclosures	79 FR 30240, 42 CFR §148.220(b)(4)(v) Bulletin 396	The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016. This applies to all insurers writing hospital indemnity policies or other fixed indemnity policies sold in the individual market in Maine, including association coverage and other coverage that is issued through non-employer groups. All policies and certificates with effective dates on or after January 1, 2015, are subject to the Final Rule. In addition, the notice requirement applies to renewals for all policy years beginning on or after January 1, 2015.	☐	
GENERAL POLICY PROVISIONS				
Classification of Coverage, Disclosure, and Minimum Standards	24-A M.R.S.A. §2694 Rule 755	These rules establish minimum standards for benefits under individual and group health insurance. These rules clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules also set minimum standards for benefits for hospital confinement indemnity coverage. The following minimum standards for benefits are prescribed for hospital confinement indemnity coverage noted in the following subsections. An individual health insurance policy or group health insurance policy or certificate hospital confinement indemnity coverage shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for hospital confinement indemnity coverage or the Superintendent finds that the policies or certificates are approvable as supplemental health insurance and the outline of coverage complies with the outline of coverage in Section 7(M) of this rule.	☐	

		The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. § 2694 that the form is intended to be in. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in 24-A M.R.S.A. § 2694. The requirements set forth in this section are in addition to any other applicable requirements as specified in Section 3(D). Must comply with all applicable provisions of Rule 755 for Major Medical coverage including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G). Must comply with all applicable provisions of Rule 755 for hospital confinement indemnity coverage including, but not limited to, Sections 4, 5, 6(A), 6(E), 7(A), 7(B), and 7(B)(F), specifically: **Sec. 4**. Policy Definitions. **Sec. 5**. Prohibited Policy Provisions **Sec. 6(A).** General Rules. **Sec. 6 (E)(1)** "Hospital confinement indemnity coverage" is a policy of health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $50 per day and not less than 31 days during any one period of confinement for each person insured under the policy. **(2)** Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.		

		(3) Except as permitted under 24-A M.R.S.A. § 2723, benefits shall be paid regardless of other coverage. **Sec. 7 (A)(1)** Application disclosure: All applications for coverages specified in Sections 6B, C, D, E, G, I, J, K and L shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: **"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."** **Sec. 7(A)(4)** Each policy of individual health insurance and group health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. **Sec. 7(A)(8)** If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations." **Sec. 7(A)(10)** All individual policies, except nonrenewable accident policies, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within ten days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificateholder is not satisfied for any reason. Ten days is a minimum; longer periods are permitted.		

		Sec. 7(A)13(a) Outlines of coverage delivered in connection with policies defined in this rule as hospital confinement indemnity (Section 6E), specified disease (Section 6J), or supplemental health coverages (Section 6L) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections F and J, the following language, which shall be printed on or attached to the first page of the outline of coverage: **"This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company."** **(b)** An insurer shall deliver to persons eligible for Medicare any notice required under Bureau of Insurance Rule Chapter 275(17)(D). **Sec. 7(A)(16)** All hospital confinement indemnity policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following: **"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."** **Sec. 7(B)** Outline of Coverage Requirements **(1)** An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual health insurance, group health insurance, dental plans, and vision plans as required in 24-A M.R.S.A. § 2695. This requirement shall not apply to group major medical policies and certificates issued to employer groups as described in 24-A M.R.S.A. § 2804 and labor union groups as described in 24-A M.R.S.A. § 2805. Except as provided in Section 10, all outlines of coverage used in this state require the approval of the Superintendent.		

		(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued."** **(3)** In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the Superintendent for prior approval. **(4)** An outline of coverage may take the form or an advertisement provided that it satisfies the standards specified for outlines of coverage in 24-A M.R.S.A. § 2695(8) as well as this rule. **Sec. 7(B)(F)** Hospital Confinement Indemnity Coverage (Outline of Coverage) An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 6(E) of this rule. The items included in the outline of coverage must appear in the sequence prescribed: [COMPANY NAME] HOSPITAL CONFINEMENT INDEMNITY COVERAGE THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES		

		OUTLINE OF COVERAGE **(1)** Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY! **(2)** Hospital confinement indemnity coverage is designed to provide coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below. **(3)** [A brief specific description of the benefits in the following order: (a) Daily benefit payable during hospital confinement; and (b) Duration of benefit described in (a). The description of benefits shall be stated clearly and concisely.] **(4)** [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or, in any other manner, operate to qualify payment of the benefit, described in Paragraph (3) above.] **(5)** [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.] **(6)** [Any benefits provided in addition to the daily hospital benefit.]		
Definition Of Emergency Services & Medical Condition	Rule 850, Sec. 5(O) & 5(P)	Acute symptoms that if not medically attended to could result in placing the health, physical or mental, of the individual (or unborn child) in serious jeopardy; serious impairment of bodily functions; serious dysfunction of bodily organ or part; for pregnant women if	☐	

		having contractions and there is inadequate time to transfer to another hospital or there is a safety issue involved. Includes prudent layperson language		
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	24-A M.R.S.A. §2413	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	☐	
Extension of Benefits	24-A M.R.S.A. §2849-A	Must provide an extension of benefits of at least 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.	☐	
Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies	Rule 275, Sec. 17(D)	There must be a notice predominantly displayed on the first page of the policy that states: **"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."**	☐	
Preexisting Conditions	Rule 755(8)	If a policy or certificate contains any limitations with respect to preexisting conditions, the limitation shall appear as a separate paragraph of the policy or certificate and be labeled as "**PREEXISTING CONDITION LIMITATION.**"	☐	
Prohibited practices	24-A M.R.S.A. §2736-C(3)(A)	An enrollee may not be cancelled or denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage.	☐	
Rate Filing	24-A M.R.S.A. §2736	1. Filing of rate information. Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. 2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine	☐	

		whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing.		
Rebates	§2160 §2163-A Bulletin 382	Are there any provisions that give the insured a benefit not associated with indemnification or loss?" Yes ___ No ___	☐	
Renewal provision	24-A M.R.S.A. §2820	Policy must contain the terms under which the policy can or cannot be renewed prominently on first page of policy or certificate.	☐	
Statements in Applications	24-A M.R.S.A. §2818	There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties.	☐	
Third Party Notice of Cancellation	24-A M.R.S.A. §2707-A, Rule 580	Third party 10 day prior notice of cancellation and reinstatement for cognitive impairment or functional incapacity.	☐	
Time for Suits	24-A M.R.S.A. §2828	No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	☐	
Time limit on certain defenses	24-A M.R.S.A. §2847-C Rule 580	There shall be a provision that from the date of issue of a policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such 3-year period.	☐	
ELIGIBILITY/ENROLLMENT				
Definition of Dependent	24-A M.R.S.A. §2833	Children (including stepchildren, adopted children or children placed for adoption) under the age of 19. Cannot use financial dependency as a requirement for eligibility. Adopted, or placed for adoption children are to be provided the same benefits as natural dependent children and stepchildren.	☐	

CLAIMS & UTILIZATION REVIEW				
Examination, autopsy	24-A M.R.S.A. §2826	There shall be a provision that the insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not prohibited by law.	☐	
Forms for proof of loss	24-A M.R.S.A §2825	There shall be a provision that the insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.	☐	
Limits on priority liens/subrogation	24-A M.R.S.A. §2836	Does this policy have subrogation provisions? If yes, see provisions below: Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien.	☐	**Yes** ☐ **Please provide citation for section in policy** _____ **No** ☐
Notice of Claim	24-A M.R.S.A. §2823	There shall be a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.	☐	
Payment of Claims	24-A M.R.S.A. §2436	A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer.	☐	
Penalty for failure to notify of hospitalization	24-A M.R.S.A. §2847-A	No penalty for hospitalization for emergency treatment.	☐	